THE INDIVIDUALIZED SUPPORT PLAN

State Form ( )

NOTE: When completing this form electronically, use your computer's TAB key to navigate the fields.

*THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.

Name of Individual _____ **Social Security #** _____ ☐ **Female** ☐ **Male**

Name of Facilitator _____ **Date of ISP** _____

Medical Insurance _____ ☐ **Initial** ☐ **Revised**

Individual's Personal and Demographic Information

Last Name _____ **First Name** _____ **MI** _____

Address _____

City _____ **State** _____ **Zip** _____

DOB _____ **RID#** _____ **Legal Status** _____

Current Living Arrangement: _____

The Individual is currently ☐ **In School** ☐ **Employed** ☐ **Other (Specify** _____ **)**

Individual's Diagnosis

PRIMARY _____ **SECONDARY** _____

Individual's Emergency Contacts

Name _____ **Phone #** _____ **Relationship** _____

Address _____ *If Relationship is "Other", Specify:* _____

Alternate contact method _____

Name _____ **Phone #** _____ **Relationship** _____

Address _____ *If Relationship is "Other", Specify:* _____

Alternate contact method _____

Name _____ **Phone #** _____ **Relationship** _____

Address _____ *If Relationship is "Other", Specify:* _____

Alternate contact method _____

Name _____ **Phone #** _____ **Relationship** _____

Address _____ *If Relationship is "Other", Specify:* _____

Alternate contact method _____

❖ Attach Person Centered Planning Profile Information

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Name of Individual _____

Date of Support Plan _____

Outcome towards which this Individualized Support Plan will work

Desired Outcome

Current Status

Past Experiences

Proposed Strategy/Activity	Responsible Party	Time Frame	Progress Note

Outcome ____ of ____

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Date of Support Plan ______________________

Statement of Agreement

I have been involved in the development of my Individualized Support Plan and I agree with this Plan. I know I can appeal to the DDARS if I disagree with how this plan is put into action.

Signed ____________________________________ Date ______________
Individual for whom this plan was written *date signed*

Signed ____________________________________ Date ______________
Guardian of Individual, if applicable *date signed*

Individualized Support Plan Participants

Participant	Relationship	Date plan was sent	Sent via
			☐ E-mail ☐ Postal Mail ☐ Telephone ☐ In Person ☐ Fax
			☐ E-mail ☐ Postal Mail ☐ Telephone ☐ In Person ☐ Fax
			☐ E-mail ☐ Postal Mail ☐ Telephone ☐ In Person ☐ Fax
			☐ E-mail ☐ Postal Mail ☐ Telephone ☐ In Person ☐ Fax
			☐ E-mail ☐ Postal Mail ☐ Telephone ☐ In Person ☐ Fax
			☐ E-mail ☐ Postal Mail ☐ Telephone ☐ In Person ☐ Fax
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			☐ E-mail ☐ Postal Mail ☐ Telephone ☐ In Person ☐ Fax
			☐ E-mail ☐ Postal Mail ☐ Telephone ☐ In Person ☐ Fax

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Name of Individual _____

Date of Support Plan _____

Meeting Issues and Requirements

Comments boxes will expand to accept text

The Individualized Support Plan team shall check any of the following Health and Behavioral Issues that may concern the individual and explain how they are met or addressed by this plan.	**Comments**
☐ **If a Provider is needed to provide health and behavioral support (Name the provider responsible)**	
☐ **Seizures, or History of Seizures**	
☐ **Allergies, or History of Allergies**	
☐ **Uses or Requires Dentures**	
☐ **Chewing Difficulties**	
☐ **Swallowing Difficulties**	
☐ **Dining Difficulties**	
☐ **Vision Difficulties**	
☐ **Hearing Difficulties**	
☐ **Speaking Difficulties / Mode of Communication**	
☐ **Behavior Issues**	
☐ **Issues discovered through review of Incident Reports**	
☐ **Medication/Self Medication Issues**	
☐ **Lab Testing**	
☐ **Other chronic conditions or healthcare issues**	

☐ **Regular family physician**	
☐ **Dentist**	
☐ **Specialist (seizures, mental health issues, etc.)**	

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Name of Individual _____

Date of Support Plan _____

Meeting Issues and Requirements

Comments boxes will expand to accept text

The Individualized Support Plan Team must show which of the following Safety and Environmental Requirements have been met by this Plan, and how.	**Comments**
☐ **If a Provider is needed to provide environmental and living arrangement support (Name provider responsible)**	
☐ **Carbon Monoxide Detectors**	
☐ **Smoke Detectors**	
☐ **Emergency Phone Numbers**	
☐ **Emergency Evacuation Routes and Plan**	
☐ **Fire Extinguishers**	
☐ **Insurance**	
☐ **Anti-Scalding Devices**	
☐ **Devices and Home Modifications**	
☐ **Personal Emergency Response System**	
☐ **Current Photograph in Personal File**	
☐ **Transportation**	
☐ **Individual's Property/Financial Resources (Name provider)**	

The Individualized Support Plan Team must show which of the following Provider Requirements have been met by this Plan, and how.	**Comments**
☐ **1st Case Manager contact after ISP implementation**	
☐ **Frequency of Case Manager monitoring visits**	
☐ **Maintaining individual's personal file (Name provider)**	
☐ **Analyzing and updating of records (Frequency)**	
☐ **Frequency at which Individual is informed of** ☐ Medical Condition ☐ Developmental Status ☐ Behavior Status ☐ Risk of Treatment	

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Optional Attachment: Resources

This individual is currently receiving funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

If Individual is receiving Waiver funds, which Waiver? _____

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

The team and the individual discussed funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ All Medicaid Waivers

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

This individual does not desire funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

Which Waiver(s)? _____

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

This individual has applied for funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

Which Waiver(s)? _____

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

This individual is currently on a waiting list for the following supports:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

Which Waiver(s)? _____

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments: